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24 August 2017

Version of attached file:

Published Version

Peer-review status of attached file:

Peer-reviewed

Citation for published item:

McNeill, Desmond and Birkbeck, Carolyn Deere and Fukuda-Parr, Sakiko and Grover, Anand and Schrecker, Ted and Stuckler, David (2017) 'Trade and investment agreements : implications for health protection.', *Journal of world trade.*, 51 (1). pp. 159-182.

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Trade and Investment Agreements: Implications for Health Protection

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Trade and Investment Agreements (TIAs) have been widely criticized for their potentially negative effects on health. Many governments, particularly from low- and middle-income countries, have voiced concerns that mega-regional agreements such as the Trans-Pacific Partnership agreement, and the Transatlantic Trade and Investment Partnership, will erode governments' scope for health protection, weakening for instance those options that remain permissible under World Trade Organization rules. Further, these mega-regional agreements will set default standards and rules of the game that even non-signatories will need to emulate in order to be competitive in the global market.

This article begins by reviewing the changing structure of trade and investment policy, global production, and the relation between the two. The effects of TIAs on health are then analysed, based on some of the most relevant evidence. Key power asymmetries within the global trade and investment architecture are described, and the way they influence how trade rules are made, implemented and adjudicated. Section 5 examines a particularly striking and topical instance of such power asymmetries, investor-state dispute settlement provisions in TIAs, and their relevance to health. The article concludes with recommendations to mitigate the potential negative health externalities of TIAs.

1 INTRODUCTION

Trade and Investment Agreements (TIAs) have been widely criticized for their potentially negative effects on health.^{1,2,3} Concern is rising in the wake of the

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¹ Kapczynski, A., *The Trans-Pacific Partnership – Is It Bad for Your Health?* 373 New Eng. J. Med. 201–203 (2015).

² Luo, J. & Kesselheim, AS., *The Trans-Pacific Partnership Agreement and Implications for Access to Essential Medicines* (JAMA 2015).

³ Weiss M, Middleton J. & Schrecker, T., *Warning: TTIP Could Be Hazardous to Your Health*, 37 J. Pub. Health 367–369 (2015).

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Trans-Pacific Partnership (TPP) agreement, signed in February 2016, and the Transatlantic Trade and Investment Partnership (TTIP) now under negotiation between the United States (US) and the European Union (EU). These ‘mega-regional’ agreements are the new wave in trade policy, and if they come into force TPP and TTIP will together affect more than half of world trade.^{4,5} Many governments, particularly from low- and middle-income countries (LMICs), have voiced concerns that these mega-regional agreements go ‘deeper and beyond existing ... contractual obligations and disciplines’ found in other trade agreements⁶ and will erode governments’ scope for health protection, weakening for instance those options that remain permissible under World Trade Organization (WTO) rules. Further, the reach of the mega-regionals will extend well beyond their signatory countries by setting default standards and rules of the game that even non-signatories of these new agreements will need to emulate in order to be competitive in the global market.^{7,8,9} The call from health advocates around the world call for trade and investment rules that better reflect health priorities is backed by a growing body of new evidence of the ways international trade and investment impact how people work, what they consume and how products are made in ways that affect health outcomes.

The mega-regionals come at a time when trade disputes increasingly centre on the role of health protections.¹⁰ In 2015 the WTO Technical Barriers to Trade (TBT) Committee received fifty-four specific trade concerns, a record high, and about 1/3rd of these pertain to public health. The Barriers to Trade committee notes:

Health protection and labelling, particularly for food and drink, are emerging as a dominant theme in many of the ‘specific trade concerns’ that members raise in the committee. They highlight the balance governments try to strike between trade and health —reducing obesity, discouraging unhealthy eating and alcohol abuse, protecting children, for example, by regulation or by helping consumers to be better informed so they can choose for themselves.

⁴ TPP: 26.3%; TTIP: 43.6% (Source: WTO 2014). ‘WT/TPR/OV/16’, obtained from the World Bank’s World Development Indicators, WTO Statistics and UNSD Comtrade database.

⁵ Meléndez-Ortiz, R., *Mega-regionals: What is Going on?*, in *Mega-regional Trade Agreements: Game-Changers or Costly Distractions for the World Trading System?* 13–14. (Global Agenda Council on Trade & Foreign Direct Investment ed., Geneva: World Economic Forum 2014), <http://www10.iadb.org/intal/intalcdi/PE/2014/14548.pdf>.

⁶ *Ibid.*

⁷ Jones, E., Deere Birkbeck, C., & Woods, N., *Manoeuvring at the Margins: Constraints Faced by Small States in International Trade Relations* (London: Commonwealth Secretariat 2010).

⁸ Yu, P. K., *TPP and Trans-Pacific Perplexities*, 37 *Fordham Intl. L.J.* 1129–1182 (2014).

⁹ Jones, E., *Which Way Forward for the WTO? The Plurilaterals Debate, Background Note* (Oxford: Global Economic Governance Programme, University of Oxford 2014), <http://www.globaleconomicgovernance.org/sites/geg/files/WTO%20Plurilaterals%20Background%20Note.pdf>.

¹⁰ WTO, *Overview of Developments in the International Trading Environment – Annual Report by the Director-General – WT/TPR/OV/14*, 21 Nov. 2011 (2014).

(While some countries are concerned to implement fiscal and regulatory measures to protect their health, in some cases it has been speculated they argue on health grounds illegitimately in order to introduce protections which would favour domestic industries).

To the extent trade agreements themselves impact on health, they may come into conflict with other international agreements, most notably the International Covenant on Economic, Social and Cultural Rights (ICESCR) and other human rights agreements which provide an obligation to respect, protect and fulfil individuals' right to the highest attainable standard of physical and mental health (the right to health) and to take no measures that would negatively affect the right (retrogressive measures). This includes not only access to healthcare but also clean water, nutritious food, and a safe work environment. Notably, debate surrounding the intellectual property (IP) provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which may constrain access to essential medicines in public health emergencies, has spurred the United Nations Secretary General to establish a High Level Panel to 'recommend solutions to remedying the policy incoherence between the justifiable rights of inventors, international human rights law, trade rules and public health in the context of health technologies that is impeding access and the right to health for millions.'¹¹ In 2011, the United Nations Special Rapporteur on the Right to Food recommended that 'Human rights impact assessments of trade and investment agreements should be prepared prior to the conclusion of the agreements and in time to influence the outcomes of the negotiations', with outcomes up to and including 'amendment' or 'termination of the agreement'.^{12,13}

To address these debates it is first important to understand how trade agreements designed to increase trade flows affect public health. It is indisputable that they impact on health outcomes, but questions remain as to how and to what degree. In 2001, a widely cited article in the *British Medical Journal* asserted that 'globalisation is good for your health, mostly',¹⁴ claiming that increased openness

¹¹ UN SG, *Background Paper: Existing and Prior Work, Initiatives and Proposals to Improve Innovation and Access to Health Technologies* (2015), <https://static1.squarespace.com/static/562094dee4b0d00c1a3ef761/t/56da11782b8dde9c3d5865b4/1457132156145/DRAFT+Background+Paper+on+Existing+and+prior+work+initiatives+and+propo+++pdf> (see summary review of work to date UN SG's High Level Panel on Innovation and Access to Medicines).

¹² De Schutter, O., *Report of the Special Rapporteur on the Right to Food, Addendum: Guiding Principles on Human Rights Impact Assessments of Trade and Investment Agreements* (A/HRC/19/59/Add.5. New York: United Nations 2011).

¹³ Ruckert, A., Schramm, A., Labonte, R., Friel, S., Gleeson, D. & Thow, AM., *Policy Coherence, Health, and the Sustainable Development Goals: A Health-Impact Assessment of the Trans-Pacific Partnership*. (Critical Public Health published online 27 Apr. 2016), <http://www.tandfonline.com/doi/full/10.1080/09581596.2016.1178379>.

¹⁴ Feachem, R. G. A., *Globalisation is Good for Your Health, Mostly*, 323 *Brit. Med. J.* 504–506 (2001).

to trade leads to more rapid economic growth, with associated opportunities to reduce poverty and invest in health care. This claim has since been challenged,¹⁵ on grounds that it may not reduce poverty¹⁶ and could increase within-country inequalities.^{17,18,19} A 2009 *Lancet* series of papers on trade and health identified multiple mechanisms by which trade could harm health, including access to pharmaceuticals, dietary changes, and tobacco, alcohol, and other substance use, for both better and worse.^{20,21,22,23} More recently, the Lancet–University of Oslo Commission on Global Governance for Health identified TIAs as a major source of global health inequities.^{24,25} We believe there is a need to promote further debate on this issue among trade scholars.

In the following section we review the changing structure of trade and investment policy, global production, and the relation between the two. In section 3 we apply a simple conceptual framework for analysing the effects of TIAs on health and summarize some of the most relevant evidence. Section 4 describes key power asymmetries within the global trade and investment architecture, and the way they influence how trade rules are made, implemented and adjudicated. Section 5 examines a particularly striking and topical instance of such power asymmetries, investor-state dispute settlement (ISDS) provisions in TIAs, and their relevance to health. We conclude with recommendations to mitigate the potential negative health externalities of TIAs.

¹⁵ Kawachi, I. & Wamala, S., *Poverty and Inequality in a Globalizing World*, in *Globalisation and Health* 122–137 (I. Kawachi & S. Wamala, eds, Oxford: Oxford University Press 2007).

¹⁶ UNCTAD (United Nations Conference on Trade and Development), *The Least Developed Countries Report 2013: Growth with Employment for Inclusive and Sustainable Development* 24–92 (Paris: UNCTAD Secretariat 2013), http://unctad.org/en/PublicationsLibrary/ldc2013_en.pdf.

¹⁷ Birdsall, N., *The World Is Not Flat: Inequality and Injustice in Our Global Economy*, *WIDER Annual Lecture* (Helsinki: World Institute for Development Economics Research 2006), http://www.wider.unu.edu/publications/annual-lectures/en_GB/AL9/_files/78121127186268214/default/annual-lecture-2005.pdf.

¹⁸ UNCTAD (United Nations Conference on Trade and Development), *Trade and Development Report 2014: Global Governance and Policy Space for Development* (New York and Geneva: United Nations 2014), http://unctad.org/en/PublicationsLibrary/tdr2014_en.pdf.

¹⁹ Bourguignon, F., *The Globalization of Inequality* (Princeton: Princeton University Press 2015).

²⁰ Callard, C., Chitanondh, H. & Weissman, R., *Why Trade and Investment Liberalisation May Threaten Effective Tobacco Control Efforts*, 10 *Tobacco Control* 68–70 (2001).

²¹ Chanda, R., *Trade in Health Services*, 80(2) *Bull. World Health Org.* 158–163 (2002).

²² Rayner, G., Hawkes, C., Lang, T. & Bello, W., *Trade Liberalisation and the Diet Transition: A Public Health Response*, 21(1) *Health Promotion Intl.* 67–74 (2006).

²³ Thow, AM. & Hawkes, C., *The Implications of Trade Liberalization for Diet and Health: A Case Study from Central America*, 5(5) *Global Health* (2009).

²⁴ Ottersen, O. P., Dasgupta, J., Blouin, C., Buss, P., Chongsuvivatwong, V., Frenk, J. et al., *The Political Origins of Health Inequity: Prospects for Change*, 383 *The Lancet* 630–667 (2014).

²⁵ The present article is prepared by members of the Independent Panel on Global Governance for Health, established to follow up the work of the Commission.

2 TRADE AND INVESTMENT AGREEMENTS IN THE TWENTY-FIRST CENTURY

Since the establishment of the General Agreement on Trade and Tariffs in 1948 (later replaced by the WTO), four major shifts of relevance to health have occurred.

First, trade increasingly covers not only tangible goods but also services, including finance and information.

Second, trade has come to be dominated by large companies and a complex web of global value chains. It is estimated that approximately 80% of global trade involves global value chains that are controlled by transnational companies (TNCs).²⁶ This change in the geography of global production means that trade and investment (or contract production) are increasingly substitutes for one another; one way of conceptualizing this change is in terms of a shift from trade in goods to trade in tasks.²⁷

Third, the establishment of the WTO created a powerful, binding dispute settlement procedure in which sanctions can be imposed against countries that lose a case and fail to bring their measures into conformity with WTO obligations in a reasonable period of time. This means that disputes about health may take place not in domestic courts but in the dispute settlement process.

Fourth, TIAs – which now largely overshadow the deadlocked WTO negotiating process – now address not only trade but also investment. They thus intrude significantly on the ‘policy space’ of signatory countries: ‘the freedom, scope, and mechanisms that governments have to choose, design, and implement public policies to fulfill their aims’.²⁸

3 HOW TRADE AGREEMENTS IMPACT PUBLIC HEALTH

The effects of trade liberalization on poverty and inequality must be considered in any analysis of health impacts, as demonstrated by a substantial literature on social determinants of health.^{29,30} Trade liberalization creates winners and losers. The theoretical economic case for liberalization is based on the presumption that

²⁶ UNCTAD (United Nations Conference on Trade and Development), *World Investment Report 2013: Global Value Chains: Investment and Trade for Development* (New York and Geneva: United Nations 2013).

²⁷ Grossman, G. M. & Rossi-Hansberg, E., *The Rise of Offshoring: It's Not Wine for Cloth Anymore*, The New Economic Geography: Effects and Policy Implications 59–102 (Kansas City: Federal Reserve Bank of Kansas City 2006), <http://www.frbkc.org/Publicat/Sympos/2006/PDF/8GrossmanandRossi-Hansberg.pdf>.

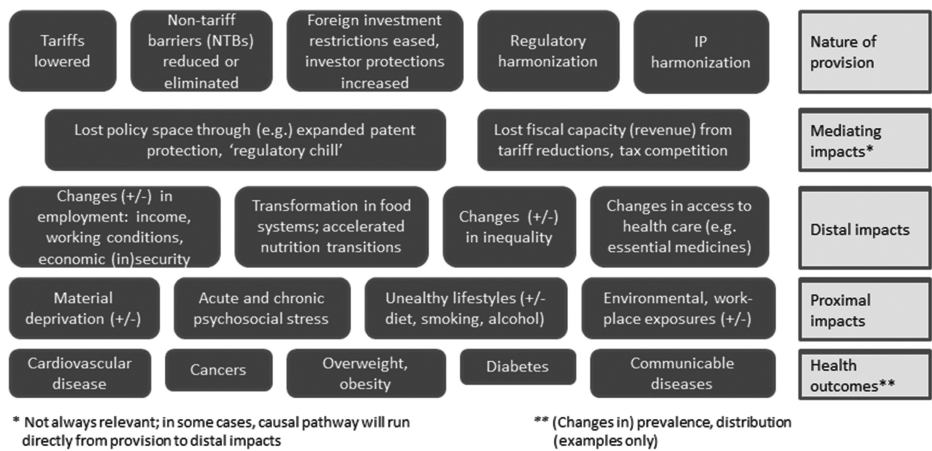
²⁸ Koivusalo, M., Schrecker, T., & Labonté, R., *Globalization and Policy Space for Health and Social Determinants of Health*, in *Globalization and Health: Pathways, Evidence and Policy* 105 (R. Labonté, T. Schrecker, C. Packer, & V. Runnels eds, New York: Routledge 2009).

²⁹ See e.g. Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on Social Determinants of Health* (Geneva: World Health Organization 2008), http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

³⁰ See e.g. Kelly, M. & Doohan, E., *The Social Determinants of Health*, in *Global Health: Diseases, Programs, Systems and Policies* 75–114 (M. Merson, R. Black & A. Mills eds, Burlington, MA: Jones & Bartlett 2012).

losers will be compensated through the redistribution of some portion of the aggregate economic gains from expanded trade, but this may or may not actually occur. Recent model-based analyses of the anticipated economic effects of the TTIP and TPP find that both will lead to a declining labour share of national income and, in some countries, will not promote growth at all.^{31,32} Trade agreements – as the prime instrument for trade liberalization – can impact health also in other ways, for better or worse. Figure 1, based on the analysis of Blouin et al.,³³ provides a heuristic that shows how loss of policy space and loss of government revenue³⁴ can lead to negative health outcomes. Apart from possible changes in inequality (just mentioned) our analysis focuses on three main ‘distal impacts’ – labour conditions, food, and health care. In the following we summarise evidence regarding these three types of health effect, and how TIAs may exacerbate the situation.

Figure 1 A Generic Framework for Thinking About Trade/Investment Agreements and Health



³¹ Capaldo, J., *The Trans-Atlantic Trade and Investment Partnership: European Disintegration, Unemployment and Instability* (GDAE Working Paper No. 14-03. Medford, MA: Global Development and Environment Institute, Tufts University 2014), <http://www.ase.tufts.edu/gdae/Pubs/wp/14-03CapaldoTTIP.pdf>.

³² Capaldo, J., Izurieta, A., & Sundaram, J. K., *Trading Down: Unemployment, Inequality and Other Risks of the Trans-Pacific Partnership Agreement* (GDAE Working Paper No. 16-01. Medford, MA: Global Development and Environment Institute, Tufts University 2016), <http://www.ase.tufts.edu/gdae/Pubs/wp/16-01Capaldo-IzurietaTPP.pdf>.

³³ Blouin, C., Chopra, M., & van der Hoeven, R., *Trade and Social Determinants of Health*, 373 *The Lancet* 502-507 (2009).

³⁴ Lost revenue can also be considered a constraint on policy space, by limiting scope and capacity for implementation.

Food: a number of case studies in Central America, Asia and the Pacific identify increased penetration of low- and middle-income country (LMIC) markets by supermarkets, fast food restaurants, and the manufacturers and distributors of processed foods after entering into TIAs that reduced barriers to imports and investment.³⁵ For example, the removal of trade and investment barriers between the US and Mexico was followed by increasing US exports and Mexican consumption of processed meats, and declining consumption of grains and pulses.^{36,37}

A number of studies have attempted to better establish causality based on more rigorous econometric analysis. One cross-sectional analysis of fifty low- and middle- income countries found that countries with trade agreements with the US have 50% higher levels of soft-drink consumption per capita than those that do not; higher foreign investment as a proportion of Gross Domestic Product (GDP) was also associated with increased levels of processed meat and alcohol consumption.³⁸ In addition, a natural experiment in Vietnam identified that annual growth in soft-drink sales per capita increased by 8.8 % after joining the WTO, which was unmatched with the control country the Philippines.³⁹ One study combining individual-level data and an index of globalization found that increased economic globalization was also associated with higher body-mass index among women in fifty-six LMICs, although stronger associations were observed with political and social dimensions of the globalization index.⁴⁰ Given a strong-reliance on time-series analyses the evidence of a causal effect of TIAs on consumption of unhealthy processed foods and beverages and health precludes definitive conclusions⁴¹; yet, the consistency in these findings suggest that TIAs

³⁵ Friel, S., Hattersley, L., & Townsend, R., *Trade Policy and Public Health* 36 Annual Rev. Pub. Health 325–344 (2015).

³⁶ Clark, S. E., Hawkes, C., Murphy, S. M. E., Hansen-Kuhn, K. A., & Wallinga, D., *Exporting Obesity: US Farm and Trade Policy and the Transformation of the Mexican Consumer Food Environment* 18 Intl. J. Occupational & Env'tl. Health 53–64 (2012).

³⁷ Goran, M. I., Ulijaszek, S. J., & Ventura, E. E., *High Fructose Corn Syrup and Diabetes Prevalence: A Global Perspective*, 8 Global Pub. Health 55–64 (2013).

³⁸ Stuckler, D., McKee, M., Ebrahim, S., & Basu, S., *Manufacturing Epidemics: The Role of Global Producers in Increased Consumption of Unhealthy Commodities Including Processed Foods, Alcohol, and Tobacco*, 9 PLoS Med e1001235 (2012).

³⁹ Schram, A., Labonte, R., Baker, P., Friel, S., Reeves, A., & Stuckler, D., *The Role of Trade and Investment Liberalization in the Sugar-Sweetened Carbonated Beverages Market: A Natural Experiment Contrasting Vietnam and the Philippines*, 11(1) Global. Health (2015).

⁴⁰ Goryakin, Y., Lobstein, T., James, W. P. T., & Suhrcke, M., *The Impact of Economic, Political and Social Globalization on Overweight and Obesity in the 56 Low and Middle Income Countries*, 133 Soc. Sci. & Med. 67–76 (2015).

⁴¹ Barlow, P., & Stuckler, D., *How Do Trade Agreements Affect Public Health? A Systematic Literature Review and Network Co-citation Analysis* (manuscript under review)

could lead to accelerated nutrition transitions toward unhealthy foods and an accompanying rise of overweight and obesity.^{42,43,44,45,46}

The provisions within TIAs may also limit the ability of countries to warn of health hazards associated with alcohol, tobacco and unhealthy processed foods, and that are effective in discouraging consumption.⁴⁷ Issues related to tobacco are discussed elsewhere in the paper, but a particularly relevant concern is that ‘a legal clause in a trade agreement can limit the power of a state to protect the public from a product that kills if used in the manner for which it is produced’ which is considered a ‘weakness of the system’s protective architecture’.⁴⁸ For example, Thailand’s restrictions on alcohol labelling have been challenged by several countries under the TBT Agreement.⁴⁹ Legal clauses limiting such regulations may not only restrict the ability to implement a set of policies, but may also precipitate ‘regulatory chill’ whereby governments retract, alter or reconsider regulations that favour health due to fears that these may fall foul of trade agreements; that trade sanctions may be imposed by trading partners; or that decisions taken by relevant dispute settlement bodies will force governments to retract particular health policies and laws or pay compensation. TIAs can therefore potentially increase access to tobacco and processed food as outlined above, whilst simultaneously forsaking opportunities to regulate in ways that could mitigate these impacts.

In a long-running dispute between the US and the EU, the US has levied levy duties on imports from the EU in response to the latter’s prohibition on the sale of meat from cattle treated with human growth hormone.⁵⁰ In the EU, the precautionary principle is entrenched in a number of laws, covering ‘those specific circumstances where scientific evidence is insufficient, inconclusive or uncertain

⁴² Popkin, B. M., *Global Context of Obesity*, in *Handbook of Obesity Prevention* 227–238 (S. Kumanyika & R.C. Brownson eds, New York: Springer US 2007), http://dx.doi.org/10.1007/978-0-387-47860-9_11.

⁴³ Popkin, B. M., Adair, L. S., & Ng, S. W., *Global Nutrition Transition and the Pandemic of Obesity in Developing Countries*, 70 *Nutrition Rev.* 3–21 (2012).

⁴⁴ Hawkes, C., Friel, S., Lobstein, T., & Lang, T., *Linking Agricultural Policies with Obesity and Noncommunicable Diseases: A New Perspective for a Globalising World*, 37 *Food Policy* 343–353 (2012).

⁴⁵ Monteiro, C. A., Moubarac, J. C., Cannon, G., Ng, S. W., & Popkin, B., *Ultra-Processed Products are Becoming Dominant in the Global Food System*, 14 *Obesity Rev.* 21–28 (2013).

⁴⁶ Popkin, B. M., *Nutrition, Agriculture and the Global Food System in Low and Middle Income Countries*, 47 *Food Policy* 91–96 (2014).

⁴⁷ Friel, S., Gleeson, D., Thow, A-M., Labonte, R., Stuckler, D., Kay, A., & Snowdon, W., *A New Generation of Trade Policy: Potential Risks to Diet-Related Health from the Trans Pacific Partnership Agreement*, 9 *Global Health* 46 (2013), <https://globalizationandhealth.biomedcentral.com/articles/10.1186/1744-8603-9-46>.

⁴⁸ Friel, S., Hattersley, L., & Townsend, R., *Trade Policy and Public Health*, 36 *Annual Rev. Pub. Health* 325–344, 331 (2015).

⁴⁹ *Ibid.*, at 331–332.

⁵⁰ Johnson, R., *The US-EU Beef Hormone Dispute No. R40449* (Washington, DC: Congressional Research Service 2015), <https://www.fas.org/sgp/crs/row/R40449.pdf>.

and there are indications through preliminary objective scientific evaluation that there are reasonable grounds for concern that the potentially dangerous effects on the environment, human, animal or plant health may be inconsistent with the chosen level of protection'.⁵¹ There is little doubt that the precautionary principle is often invoked in ways that aim to boost or protect opportunities for local producers and thereby discriminate against foreign producers. However, there are cases where the core motivation is indeed to protect environmental or health objectives. It is significant that the European Commission (EC), in negotiating TTIP on behalf of EU member countries, is promoting 'SPS-plus' provisions that go far beyond those in the WTO's Agreement on Sanitary and Phytosanitary Standards (SPS).^{52,53}

Employment: Unemployment can negatively impact psychological and somatic health (Bartley, 1994; Paul and Moser, 2009), and changes in the types of skills that are demanded as a consequence of TIAs may induce short-term unemployment whilst workers find new jobs.⁵⁴ This can also translate into long-term unemployment if workers are unable to retrain, or migrate in order to find new jobs, suggesting a potentially critical role for labour market policy.^{55,56} Although the causal linkages are complex, trade liberalization is also associated with increased segmentation of labour markets and the rise of precarious employment,⁵⁷ which has been identified as an important negative influence on health.⁵⁸ When TIAs are ratified between high-income countries with scarce unskilled labour and LMICs abundant in labour, it may be that TIAs negatively impact on health by increasing employment in labour-intensive industries with poor working conditions. Yet, the outcome is not clear-cut when considering the possible counterfactual: as unpalatable as the situation may be, even low-wage, arduous jobs such as those in Export

⁵¹ Commission of the European Communities, *Communication from the Commission on the Precautionary Principle* (COM(2000)1. Brussels: European Commission 2000), http://ec.europa.eu/dgs/health_consumer/library/pub/pub07_en.pdf.

⁵² https://www.wto.org/english/tratop_e/sps_e/spsagr_e.htm.

⁵³ European Commission, *Trade Cross-cutting Disciplines and Institutional Provisions: Initial EU Position Paper* (Brussels: European Commission 2013), http://trade.ec.europa.eu/doclib/docs/2013/july/tradoc_151622.pdf.

⁵⁴ Autor, D. H., Dorn, D., & Hanson, G. H., *The China Shock: Learning from Labor Market Adjustment to Large Changes in Trade*, 8(1) Annual Rev. Econ. (2016).

⁵⁵ Krugman, P. R., Obstfeld, M., & Melitz, M., *International Trade: Theory and Policy* (Prentice Hall 2015).

⁵⁶ Barlow & Stuckler, *supra* n. 41.

⁵⁷ Schrecker, T., *Labor Markets, Equity, and Social Determinants of Health*, in *Globalization and Health: Pathways, Evidence and Policy* 81–104 (R. Labonté, T. Schrecker, C. Packer, & V. Runnels eds, New York: Routledge 2009).

⁵⁸ Benach, J., Vives, A., Amable, M., Vanroelen, C., Tarafa, G., & Muntaner, C., *Precarious Employment: Understanding an Emerging Social Determinant of Health*, 35 Annual Rev. Pub. Health 229–253 (2014).

Processing Zone garment factories may represent an improvement on the life chances that would otherwise be unavailable.⁵⁹

TIAs can affect labour regulations by changing the political and economic contexts that influence policy space. Cross-national comparisons draw unclear conclusions on the effects of trade and foreign direct investment (FDI) on labour standards, with some studies identifying a positive correlation between the adoption of core labour standard and increased trade, but not FDI.^{60,61,62} Others identify a positive correlation running in the opposite direction whereby reducing labour regulations increases FDI but not vice versa.⁶³ Formal recognition of the right to free association and collective bargaining (for example) is not necessarily reflected in conditions 'on the ground', so these findings should be treated with caution. Furthermore, these studies do not capture potential 'regulatory chill' effects. In summary, TIAs may lead to the changes to labour standards we have outlined above, whilst also limiting opportunities for mitigating their health effects.

Health services the provisions within the agreements that affect access to medicines are a good illustration of the way TIAs affect health by limiting policy space. IP rights relating to medicines that were established by TRIPS (1994), and moderated by the Doha declaration (2001), are now again strengthened through 'TRIPS plus', which is included in TIAs such as the TPP. As an example of how patents can affect prices, HIV AIDS retrovirals were sold at about USD 15,000 under patent in 2001. Cipla offered them for USD 350 at that time. Now they are manufactured by generics companies for USD 65.⁶⁴ By virtue of TRIPS 'flexibilities', countries are permitted to use compulsory licences to make patented drugs more affordable under certain circumstances.⁶⁵ There is some evidence that granting compulsory licenses (CL) can increase access to pharmaceuticals. For example, between 2006 and 2008 Thailand granted import licenses for generic equivalents of seven patented drugs used in treating cancer and heart disease. Although it is

⁵⁹ Kabeer, N. & Mahmud, S., *Rags, Riches and Women Workers: Export-oriented Garment Manufacturing in Bangladesh*, in *Chains of Fortune: Linking Women Producers and Workers with Global Markets* 133–164 (M. Carr ed., London: Commonwealth Secretariat 2004), <http://wiego.org/sites/wiego.org/files/publications/files/Kabeer-Mahmud-Export-Oriented-Garment-Bangladesh.pdf>.

⁶⁰ Neumayer, E. & De Soysa, I., *Trade Openness, Foreign Direct Investment and Child Labor*, 33 *World Dev.* 43–63 (2005).

⁶¹ Neumayer, E. & De Soysa, I., *Globalization and the Right to Free Association and Collective Bargaining: An Empirical Analysis*, 34 *World Dev.* 31–49 (2006).

⁶² Neumayer, E. & De Soysa, I., *Globalisation, Women's Economic Rights and Forced Labour*, 30 *World Economy* 1510–1535 (2007).

⁶³ Olney, W. W., *A Race to the Bottom? Employment Protection and Foreign Direct Investment*, 91(2) *J. Intl. Econ.* 191–203 (2013).

⁶⁴ McNeil, Donald G., *Indian Company Offers to Supply AIDS Drugs at Low Cost in Africa*, *N.Y. Times* (7 Feb. 2001), <http://www.nytimes.com/2001/02/07/world/indian-company-offers-to-supply-aids-drugs-at-low-cost-in-africa.html>.

⁶⁵ 't Hoen, E., Berger, J., Calmy, A., & Moon, S., *Driving a Decade of Change: HIV/AIDS, Patents and Access to Medicines for All*, 14 *J. Intl. AIDS Socy.* 15 (2011).

difficult to estimate the number of lives saved as a consequences of granting licenses, an extrapolation of trends before the licenses were granted compared with actual access rates suggests that an additional 84,158 patients received access to the drugs and 12,493 QALYs were gained due to the reforms.⁶⁶ But In practice, the Thai case is exceptional: only a limited number of CLs have been issued. A decade after the 2001 Doha Declaration on TRIPS and public health affirmed these flexibilities there were ‘few instances’ of CLs for diseases other than AIDS, and none ‘for high-impact diseases with patented treatments such as malaria, multi-drug resistant tuberculosis, or sepsis’.⁶⁷ This may be because as of April 2015, 5% of the drugs on WHO’s essential medicines list were under patent protection, although this is likely to change in future.⁶⁸ Governments are also presented with the potential challenge of choosing between seeking to use TRIPS flexibilities and gaining access to trading partners’ markets. Meanwhile, the US in particular has attempted to negotiate higher levels of IP protection – ‘TRIPS-plus’ provisions – in bilateral and regional TIAs, which provide an additional barrier to affordable access. The Central American Free Trade Agreement (CAFTA-DR), for example, restricted Guatemalan market access of some generic drugs that are available in the US.^{69,70,71} ‘TRIPS-plus’ provisions are also being promoted by the EC and the US in TTIP.⁷²

Many TIAs have provisions or chapters on services. For the health community, particular concerns have arisen about ‘mode 3’ trade in services (which relates to ‘commercial presence’, e.g. of foreign investors in private healthcare facilities or health insurance) and from ISDS provisions, discussed in greater detail in section 5, that might entitle investors to seek compensation in the event that health services (or health insurance) currently in the private sector were taken into the public sector. For example, in the context of the UK’s National Health Service (NHS), one analysis expressed concern that expanded involvement of private contractors

⁶⁶ Yamabhai, I., Mohara, A., Tantivess, S., Chaisiri, K., & Teerawattananon, Y., *Government Use Licenses in Thailand: An Assessment of the Health and Economic Impacts*, 7(1) Global. & Health 1 (2011).

⁶⁷ Beall, R. & Kuhn, R., *Trends in Compulsory Licensing of Pharmaceuticals Since the Doha Declaration: A Database Analysis*, 9 PLoS Med e1001154 (2012).

⁶⁸ Saez, C., *WHO Reviews Its Essential Medicines List; Some New Candidates Under Patent*. Intellectual Property Watch [On-line] (2015), <http://www.ip-watch.org/2015/04/21/who-reviews-its-essential-medicines-list-some-new-candidates-under-patent/>

⁶⁹ Roffé, P., Von Braun, J., & Vivas-Eugui, D., *A New Generation of Regional and Bilateral Trade Agreements: Lessons from the US-CAFTA-DR Agreement*, in *Trade and Health: Seeking Common Ground* 41–89 (C. Blouin, N. Drager, & J. Heymann eds, Montréal: McGill–Queen’s University Press 2008).

⁷⁰ Shaffer, E. R. & Brenner, J. E., *A Trade Agreement’s Impact on Access to Generic Drugs*, 28 Health Affairs w957–w968 (2009).

⁷¹ Correa, C. M., *High Costs, Negligible Benefits from Intellectual Property Provisions in FTAs*, 44 IIC – Intl. Rev. Intell. Prop. & Competition L. 902–905, 903–904 (2013).

⁷² Bloemen, S. & Mellema, T., *Trading Away Access to Medicines – Revisited*, Joint Agency Briefing Paper (Oxford: HAI Europe and Oxfam International 2014), <http://bit.ly/1x5hJTk>.

might become ‘locked in’ due to the possibility of compensation claims by investors if alternatives are sought.^{73,74} In the ongoing Trade in Services (TiSA) negotiations, there are efforts to negotiate provisions that would limit the scope for signatories to pull back from current and future liberalization, and to omit some of the safeguards in the WTO’s existing General Agreement on Services (GATS) that permit countries to step back from a given commercial relation, such as by revoking a privatization of a previously publicly funded service. These matters are a concern for health due to the possible opportunity costs of compensation payments, and because privatization may not necessarily translate into higher quality and more equitable health-service provision.⁷⁵

In summary, TIAs can have a significant – and potentially negative – impact on health. To better understand the political economy of the processes involved, it is necessary to consider how the content and scope of TIAs are determined, including the interests they represent. There are concerns, for example, that the existing trade policy architecture incorporates a ‘mobilization of bias’ in favour of commercial goals and against health-protective regulations which infringe upon these aims. We discuss this concept and its implications in the section that follows.

4 KEY POWER ASYMMETRIES: WHAT THEY ARE AND WHY THEY MATTER

Political scientists continue to debate the nature and sources of power. However, there is widespread agreement that:

- Power can operate through control of resources (e.g. investment capital or funds needed to finance political activity);
- Power can operate through the design of institutions that favour certain interests or claims relative to others – what has been called the mobilization of bias;
- Power involves not only visible interactions in which one party prevails over another (e.g. elections, court cases) but also situations in which its operation is invisible (e.g. keeping some issues off the

⁷³ Weiss, M., *Trading Health? UK Faculty of Public Health Policy Report on the Transatlantic Trade and Investment Partnership* 94 (London: UK Faculty of Public Health 2015), <http://www.fph.org.uk/uploads/FPH%20Policy%20report%20on%20the%20Transatlantic%20Trade%20and%20Investment%20Report%20-%20FINAL.pdf>.

⁷⁴ See also Reynolds, L. & McKee, M., *Is the NHS Really Safe from International Trade Agreements?*, Brit. Med. J. (2015), doi:10.1136/bmj.h2179.

⁷⁵ lbrecht, T., *Privatization Processes in Health Care in Europe – A Move in the Right Direction, a ‘Trendy’ option, or a Step Back?*, 19(5) Eur. J. Pub. Health 448–450 (2009).

policy agenda, perhaps because of anticipated reactions) – what have been called the two faces of power.^{76,77}

Trade and investment relations among countries are asymmetrical; and all three of these forms of power are manifested in the negotiations concerning TIAs. Countries vary enormously in terms of the size of their markets, and countries with small populations and relatively low GDP may have to grant major concessions to larger, richer trading partners in order to secure even modest improvements in market access.^{78,79} This may explain, for example, situations in which LMICs agree to provisions such as TRIPs-plus measures in bilateral and regional agreements that are likely to increase health inequalities. This point assumes added importance in today's trade policy context, where action has shifted to plurilateral and regional negotiations and away from the WTO, where agreements generally require consensus among all Members and where the prospects for collective action by smaller countries to build negotiating power and defend their interests are higher. Another important asymmetry relates to the capacity of countries to assess the full implications of entering into TIAs. Here again, the devil is in the details, and the knowledge and expertise required to master this very complex field – and to negotiate effectively – is limited in many LMICs,⁸⁰ and indeed in national health departments or ministries in some high-income countries as well. Within government, it has been claimed that 'most health ministers lack domestic political muscle. They might talk tough among themselves, but back home they have to get in line behind colleagues in finance, defence, trade, and even education'.⁸¹ To the extent that this is the case, it may reflect power inequalities or asymmetries that exist not only across national borders, but also within them. It has often been observed that business occupies a generically privileged position in market economies because of its control over investment.⁸² In addition, the simple quantum of resources available to large corporations often gives them a disproportionate ability to influence public policy, to the point where (for example) it has been

⁷⁶ Lukes, S., *Power: A Radical View* (London: Macmillan 1974).

⁷⁷ Smith, R. D., *The Role of Economic Power in Influencing the Development of Global Health Governance*, 3 *Global Health Governance* (2010).

⁷⁸ Stiglitz, J. & Charlton, A., *Common Values for the Development Round*, 3 *World Trade Rev.* 495–506 (2004).

⁷⁹ Shadlen, K. C., *Exchanging Development for Market Access? Deep Integration and Industrial Policy Under Multilateral and Regional-Bilateral Trade Agreements*, 12 *Rev. Intl. Political Economy* 750–775 (2005).

⁸⁰ Jones et al., *supra* n. 7.

⁸¹ The Lancet, *What Can the UN General Assembly Do for Global Health?*, 382 *The Lancet* 1000 (2013).

⁸² Lindblom, C., *Politics and Markets: The World's Political Economic Systems* 170–221 (New York: Basic Books 1977).

observed with respect to the US position in the negotiations that led to TRIPs that ‘in effect, twelve corporations [in the information and pharmaceutical industries] made public law for the world’.⁸³ In a world of globally organised production and footloose capital, the power of TNCs is of special significance, not least because the best prospects for LMIC economic development often involve integration into global value chains (controlled by TNCs) with the hope of moving up those chains to higher-value production, despite risks such as exposure to hazardous working conditions and precarious employment relations as the price of engagement.⁸⁴ Faced with the bargaining power of TNCs, governments wishing to attract and retain foreign investment must contemplate a variety of compromises on issues ranging from labour standards to health protections. TNCs can also replace direct investment with outsourced contract production, which reduces their financial risk and enable them to limit costs by playing suppliers off one against another. The power that is exercised by strong nations and large corporations has a clear influence on how global rules are made, implemented and adjudicated.

Making the rules: In addition to, and because of, their financial resources and strategic advantages, corporate trade lobbyists have much better access to decision-makers than public health and civil society actors, at both national and international levels. As an example, during TPP negotiations in the US, private industry and trade groups represented the lion’s share of committee members – 85% of the total.^{85,86,87} Until the agreed text was published, members of the US Congress, and citizens, were denied access except through leaks and rumours. Yu⁸⁸ suggests that the absence of civil society from the negotiations was part of a much broader phenomenon of exclusion. Similarly, in the EU, the EC, the Union’s executive branch, consults regularly with representatives of major European-based industry groups,⁸⁹ through both formal and informal channels. The EC’s fourteen-member Advisory Group of experts established to advise negotiators on the TTIP talks

⁸³ Sell, S. K., *Private Power, Public Law: The Globalization of Intellectual Property Rights* (Cambridge: Cambridge University Press 2003).

⁸⁴ Abdulsamad, A., Frederick, S., Guinn, A., & Gereffi, G., *Pro-Poor Development and Power Asymmetries in Global Value Chains* (Durham: Center on Globalization, Governance & Competitiveness, Duke University 2015), http://www.cggc.duke.edu/pdfs/Pro-PoorDevelopment_and_PowerAsymmetries_inGlobalValueChains_Final.pdf.

⁸⁵ Fidler DP, Drager N, Lee K., *Managing the Pursuit of Health and Wealth: The Key Challenges*, 373 *The Lancet* 325–331 (2009).

⁸⁶ Lee K, Sridhar D, Patel M., *Bridging the Divide: Global Governance of Trade and Health*, 373 *The Lancet* 416–422 (2009).

⁸⁷ Smith RD, Correa C, Oh C., *Trade, TRIPS, and Pharmaceuticals*, 373 *The Lancet* 684–691 (2009).

⁸⁸ Yu, *supra* n. 8.

⁸⁹ Young AR, & John Peterson, *The EU and the New Trade Politics*, 13 *J. Eur. Pub. Policy* 795–814 (2006).

includes only one representative from a public health organization, but at least seven from various business sectors.⁹⁰ Major tobacco firms and pharmaceutical companies have often met privately and directly with EC officials during TTIP negotiations.⁹¹ Although the EC is also required to consult and seek input from civil society groups and the European Parliament's Committee on International Trade, these do not provide health advocates with comparable scope for obtaining information and making direct input on negotiations as they unfold. In an instance of regulatory chill, it was revealed in May 2015 that as part of the TTIP process US trade negotiators successfully pressured the EU to withdraw proposed regulations on thirty-one pesticides suspected of damaging endocrine functioning.⁹² Similarly, lobbying by the services industry spurred some governments to pursue plurilateral negotiations for an agreement on Trade in Services outside the WTO, thus removing even the limited transparency and opportunities for direct public health input available through negotiations hosted at the WTO.⁹³

Implementing the rules: Once TIAs are signed and ratified, countries – particularly LMICs – face a web of diplomatic and economic pressures to speed their implementation and to adopt measures that go even beyond the terms of those agreements.⁹⁴ In the latest round of US TIAs with LMICs, the US ratifies the agreement only after the US government agrees that the country has *already implemented* the agreement satisfactorily – underscoring the intrinsic asymmetries referred to above.⁹⁵ And through monitoring measures such as the annual 'Special 301' Watch Lists, the US identifies countries that it considers not sufficiently compliant with US preferences on IP protection and enforcement in a diplomatic warning process mandated by legislation but drawing directly on industry

⁹⁰ European Commission, *Expert Group to Advise European Commission on EU-US Trade Talks*. European Commission [On-line] (2014), http://europa.eu/rapid/press-release_IP-14-79_en.htm.

⁹¹ Gallagher, P., *TTIP Controversy: The European Commission and Big Tobacco Accused of Cover-up After Heavily Redacted Documents Released*. Independent (27 Aug. 2015), <http://www.independent.co.uk/news/uk/home-news/ttip-controversy-the-european-commission-and-big-tobacco-accused-of-cover-up-after-heavily-redacted-documents-released-10473601.html>.

⁹² Neslen, A., *EU Dropped Pesticide Laws Due to US Pressure Over TTIP, Documents Reveal*. Guardian (22 May 2015), <http://www.theguardian.com/environment/2015/may/22/eu-dropped-pesticide-laws-due-to-us-pressure-over-ttip-documents-reveal>.

⁹³ Marchetti, J. A. & Roy, M., *The Tisa Initiative: An Overview of Market Access Issues*, 38 J. World Trade 683–728 (2014).

⁹⁴ Deere, C., *The Implementation Game: The TRIPS Agreement and the Global Politics of Intellectual Property Reform in Developing Countries* (Oxford: Oxford University Press 2008).

⁹⁵ Abbott, F. M., *Intellectual Property Provisions of Bilateral and Regional Trade Agreements in Light of U.S Federal Law*, UNCTAD – ICTSD Project on IPRs and Sustainable Development Issue Paper No. 12 (Geneva: International Centre for Trade and Sustainable Development and United Nations Conference on Trade and Development 2006), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1912621.

submissions.⁹⁶ The US has used threats of trade sanctions and a suite of diplomatic pressures as well as technical assistance and training initiatives to dissuade countries from tailoring IP legislation to support public health objectives where the US has considered this contrary to the interests of its industries.^{97,98,99}

Through diplomatic and economic pressures such as these, the US has also forced some countries to abandon the pursuit of CL to achieve greater access to essential medicines.^{100,101} At the same time, governments face numerous pressures through international trade negotiations to boost IP enforcement, ostensibly to reduce trade in counterfeit goods but which may also sometimes serve to limit the availability of legal, safe, generic medicines.¹⁰² Many LMIC governments face a range of such pressures and find it difficult to navigate several different international processes simultaneously, particularly when corporate lobbyists are able to bypass foreign affairs officials and go directly to national agencies and legislatures to get laws passed.¹⁰³ In a recent example, the East African Economic Community adopted, as part of its regional cooperative arrangements, stronger provisions on IP enforcement than required by TRIPS and other measures to limit counterfeit medicines – due to direct lobbying by industry groups of national legislators of Member countries.¹⁰⁴

Adjudicating the rules: Perhaps the most important mobilization of bias related to TIAs is that governments (and in the case of ISDS provisions foreign investors) have standing to claim that their interests have been undermined by trade and investment policy decisions. Parties wishing to argue that their health has been adversely affected by the operation of TIAs have no comparable opportunities at the international level, although they may in some cases have standing in domestic legal fora. Recent disputes at the WTO have exacerbated

⁹⁶ Sell, S. K., *Industry Strategies for Intellectual Property and Trade: The Quest For TRIPS, and Post-TRIPS Strategies*, Cardozo J. Intl. Comp. L. 79–108 (2002).

⁹⁷ Deere, C., *The Implementation Game: The TRIPS Agreement and the Global Politics of Intellectual Property Reform in Developing Countries* (Oxford: Oxford University Press 2008).

⁹⁸ Morin, J.-F., Daley, K., & Gold, E. R., *Having Faith in IP: Empirical Evidence of IP Conversions*, 3 WIPO J. 93–102 (2011).

⁹⁹ Flynn, S., US Uses Special 301 To Bully Ukraine, Likely Violating WTO. Techdirt [On-line] (2013), <https://www.techdirt.com/articles/20130513/16505323067/us-uses-special-301-to-bully-ukraine-likely-violating-wto.shtml>.

¹⁰⁰ Deere, *supra* n. 97.

¹⁰¹ Smith, R. D., Correa, C., & Oh, C., *Trade, TRIPS, and Pharmaceuticals*, 373 The Lancet 684–691 (2009).

¹⁰² *The ACTA and the Plurilateral Enforcement Agenda: Genesis and Aftermath* (Roffe, P. & Seuba, X. eds, Cambridge: Cambridge University Press 2015).

¹⁰³ Panke, D., *Small States in Multilateral Negotiations. What Have We Learned?* 25 Cambridge Rev. Intl. Affairs 387–398 (2012).

¹⁰⁴ Spennemann, C., *ACTA, East African Enforcement Legislation and Generic Medicines – A Comparison*, in *The ACTA and the Plurilateral Enforcement Agenda: Genesis and Aftermath*, 244–259 (P. Roffe & X. Seuba eds, Cambridge: Cambridge University Press 2014).

concerns that trade rules can be used in ways that undermine public health, such as by challenging tobacco control measures like graphic health warnings, and the plain packaging of tobacco products, which are being implemented in Australia, Ireland and New Zealand. Whereas industry groups regularly prove successful in prompting, and in some cases financing, legal challenges at the WTO, public health advocates generally lack either the equivalent influence on trade officials or the resources to help governments finance expensive litigation.¹⁰⁵

Several WTO agreements include a general exception for measures ‘necessary to protect human, animal or plant life or health’. In principle, the WTO’s core agreements on both goods and services, for instance, provide that countries can use such exceptions to defend measures that may constitute a barrier to trade.¹⁰⁶ In the early years of WTO jurisprudence, states wishing to defend measures on the ground that they are necessary to protect health had to meet a high and unpredictable standard of proof,¹⁰⁷ and *circa* 2010, in forty cases before the WTO Dispute Settlement Body where the State raised this defence, in only one dispute did the arbitrators side with the State.¹⁰⁸ This dispute (Dispute 135: EC-Asbestos) involved the most widely recognised environmental and workplace carcinogen – asbestos. The most common reason for rejecting the validity of the health exception as invoked by the defending State was that it could not show the measure was sufficiently ‘necessary’ to protect life or health – a determination that raises the issues of competing values guiding the choice of a standard of proof, and of the willingness and ability of trade adjudicators to address these. For WTO panelists, even if the importance of the health issue at hand is recognized, their task is to determine whether the measure is undertaken in ways that respect key WTO principles, such as non-discrimination, and whether alternative options exist that would achieve the desired public policy goal with less detriment to trade. A review of proceedings to date, however, reveals that an

¹⁰⁵ Eckhardt, J. & De Bièvre, D., *Boomerangs over Lac Léman: Transnational Lobbying and Foreign Venue Shopping in WTO Dispute Settlement*, 14 *World Trade Rev.* 507–530 (2015).

¹⁰⁶ Drager, N., Beaglehole, R., Lipson, D., Mirza, Z., Rodríguez Mendoza, M., Wijkstrom, E. et al., *WTO Agreements & Public Health: A joint study by the WHO and the WTO Secretariat* 30–31 (Geneva: World Health Organization and World Trade Organization 2002), https://www.wto.org/english/res_e/booksp_e/who_wto_e.pdf.

¹⁰⁷ Howse, J. & Caldwell, M. C., *The State of Infant Health: Is There Trouble Ahead?*, in *America’s Health: State Health Rankings* (United Health Foundation ed., Seattle, WA: United Health Foundation 2004).

¹⁰⁸ McGrady, B., *Trade and Public Health: The WTO, Tobacco, Alcohol, and Diet* 130–169 (Cambridge: Cambridge University Press 2011).

implicit presumption against the validity of health-related defences, and against a precautionary approach, appears to be operating. In the realm of hard politics, in some cases the precedence of health that is theoretically accorded by the texts of WTO agreements has been challenged by governments themselves. The Canadian government for many years used WTO procedures, among other measures to defend asbestos exports against an EU prohibition.¹⁰⁹ And at the WTO, the Dominican Republic, Honduras, Cuba, Ukraine and Indonesia, with the support of large multinational tobacco companies, have challenged Australia's regime of plain packaging of tobacco products, arguing that these measures violate the TRIPS Agreement and breached articles of the Agreement on TBTs.¹¹⁰ This is an instance of a pattern in which 'internationally active firms do not just instigate their home governmental authorities to file a WTO complaint on their behalf, but sometimes also push foreign governments to file a WTO complaint against policies of their own home government'.¹¹¹

5 INVESTOR-STATE DISPUTE SETTLEMENT (ISDS)

The power asymmetry between corporate and public health constituencies is especially marked with regard to ISDS provisions in TIAs, which allow foreign investors (but not domestic firms or citizens) to challenge national laws and policies. ISDS provisions both reflect and reinforce that power asymmetry. They aim to reduce the risks for foreign investors by providing them with the right to seek arbitration in situations where the actions of a host country government have deprived them of profits, *usually including future or anticipated profits*.¹¹² Although originally established with the laudable intention of giving foreign investors protections that were not afforded by fragile host country legal systems, such provisions now offer foreign investors access to a separate, parallel channel of dispute resolution that is not accessible either to domestic entities or to citizens of the host country. Such provisions have existed in international agreements since the late 1960s, although both the number of agreements incorporating them and the number of cases initiated by investors has increased rapidly in recent years (Figure 2).

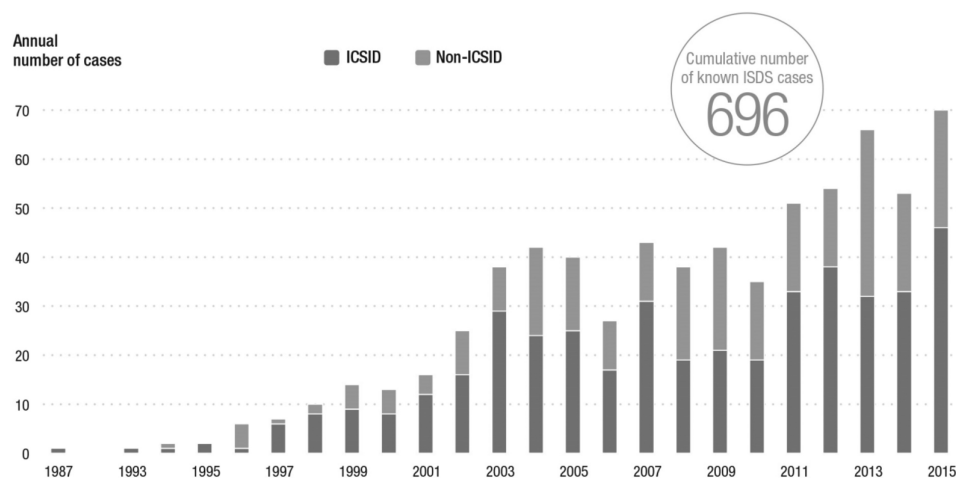
¹⁰⁹ Sentes, K. E., Oh, *Canada-we Stand on Guard for Asbestos*, 15 Can. For. Policy J. 30–49 (2009).

¹¹⁰ Eckhardt & De Bièvre, *supra* n. 105.

¹¹¹ *Ibid.*, at 508.

¹¹² UNCTAD, *supra* n. 18, at 137–140.

Figure 2 Known ISDS Cases, Annual and Cumulative, 1987–2015¹¹³



The ISDS process is based on a model of arbitration between two equal parties, but the supposedly neutral process results in multiple advantages for the investor. Only investors may bring proceedings, so states are always the defendants and not able to initiate a claim or file a counterclaim as they could in domestic courts. Because TNCs often have a legal presence in multiple countries through subsidiaries or affiliates, they can initiate ISDS under whichever investment treaty offers the most advantageous provisions (venue shopping). Other protagonists have neither legal standing under the relevant TIAs nor the opportunity to engage in this strategy.

Arbitration most often occurs through the International Centre for the Settlement of Investment Disputes (ICSID), established in 1966 as part of the World Bank group, though several other institutions exist.¹¹⁴ ISDS provisions normally require host States to participate in this arbitration process and comply with the arbitration award. The award is binding, with no right to appeal, and

¹¹³ From *World Investment Report 2016: Investor Nationality: Policy Challenges*, by United Nations Conference on Trade and Development, © (New York and Geneva: United Nations 2016). Reprinted with the permission of the United Nations, http://unctad.org/en/PublicationsLibrary/wir2016_en.pdf.

¹¹⁴ Bernasconi-Osterwalder, N. & Rostert, D., *Investment Treaty Arbitration: Opportunities to Reform Arbitral Rules and Processes* (Winnipeg: International Institute for Sustainable Development 2014), http://www.iisd.org/pdf/2014/investment_treaty_arbitration.pdf.

usually enforceable through domestic court systems,^{115,116} although a number of practical difficulties may exist. Arbitrators often only have the authority to adjudicate a dispute on the basis of the text of the agreement itself, without relying upon other resources or witnesses, and cannot look to a state's other international obligations such as those associated with human rights treaties. In addition, arbitrators often have a background in corporate law, and are drawn from a small and tightly close knit community¹¹⁷ – effectively, an ‘arbitration industry’ – that is insulated from critiques or legal challenges based on conflicts of interest.^{118,119} The lack of clear and accepted definitions of key terms and concepts such as ‘indirect expropriation’ and ‘regulatory taking’¹²⁰ that are often invoked to expand the boundaries of investors’ claims for damages both domestically and internationally allows investors (meaning in practice mainly TNCs) abundant opportunities for policy challenges. Large TNCs are not only most likely to be successful in disputes under ISDS provisions, but also have been the main beneficiaries in financial terms.¹²¹ And not only proceedings but also final decisions may be secret: for example, ‘ISDS tribunals rendered at least 43 decisions in 2014, 34 of which are public’.¹²²

ISDS provisions have been used to challenge a variety of economic, social and health policies. Such challenges have, for instance, addressed restrictions on tobacco packaging; the implementation of a minimum wage; and the decision to phase out nuclear power after the Fukushima disaster.¹²³ In parallel with the

¹¹⁵ Eckhardt, J. & De Bièvre, D., *Boomerangs over Lac Léman: Transnational Lobbying and Foreign Venue Shopping in WTO Dispute Settlement*, 14 *World Trade Rev.* 507–530 (2015).

¹¹⁶ Singh, S. & Sharma, S., *Investor-State Dispute Settlement Mechanism: The Quest for a Workable Roadmap*, 29 *Merkourios Utrecht J. Intl. Eur. L.* 88–101 (2013).

¹¹⁷ Olivet, C. & Eberhart, P., *Profiting from Crisis: How Corporations and Lawyers Are Scavenging Profits from Europe's Crisis Countries* (Brussels and Amsterdam: Corporate Europe Observatory and Transnational Institute 2014), http://corporateeurope.org/sites/default/files/profitting-from-crisis_0.pdf.

¹¹⁸ Eberhart, P. & Olivet, C., *Profiting from Injustice: How Law Firms, Arbitrators and Financiers Are Fuelling an Investment Arbitration Boom* (Brussels and Amsterdam: Corporate Europe Observatory and Transnational Institute 2012), <http://www.tni.org/sites/www.tni.org/files/download/profittingfrominjustice.pdf>.

¹¹⁹ Van Harten, G., *Why Arbitrators not Judges? Comments on the European Commission's Approach to Investor-state Arbitration in TTIP and CETA* (Toronto: Osgoode Hall Law School, York University 2014), http://eu-secretdeals.info/upload/2014/07/Van-Harten_Comments-id2466688.pdf.

¹²⁰ Rodrik, D., *The Globalization Paradox* 197–200 (New York: W.W. Norton 2011).

¹²¹ Van Harten, G. & Malysheuski, P., *Who Has Benefited Financially from Investment Treaty Arbitration? An Evaluation of the Size and Wealth of Claimants*, Osgoode Legal Studies Research Paper No. 14/2016 (Toronto: Osgoode Hall Law School 2016), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2713876.

¹²² United Nations Conference on Trade and Development, *World Investment Report 2015: Reforming International Investment Governance 1* (New York and Geneva: United Nations 2015c), http://unctad.org/en/PublicationsLibrary/wir2015_en.pdf.

¹²³ Weiss, M., *Trading Health? UK Faculty of Public Health Policy Report on the Transatlantic Trade and Investment Partnership*. (London: UK Faculty of Public Health 2015), <http://www.fph.org.uk/uploads/FPH%20Policy%20report%20on%20the%20Transatlantic%20Trade%20and%20Investment%20Report%20-%20FINAL.pdf>

industry-backed government challenges at the WTO, tobacco control measures are also under challenge through ISDS. Under the terms of an Australia-Hong Kong bilateral investment treaty a US tobacco and cigarette company, Philip Morris, challenged Australia's plain packaging requirement for tobacco products, arguing through a Hong Kong subsidiary that it had lost anticipated profits due to this measure. Although in this case unsuccessful,¹²⁴ such challenges have a strong potential dissuasive effect on governments around the world, and reinforce the notion that trade and investment principles and rules have, and should have, precedence over health rules. Similarly, under an investment agreement between Uruguay and Switzerland, Philip Morris has used its Swiss subsidiary to challenge Uruguay's graphic health warnings for tobacco products.¹²⁵ These examples illustrate the powerful commercial pressures that governments can face, exercised through use of the TIA provisions, in their efforts to protect health.

The TTIP and the TPP, with the text of the latter now released and awaiting ratification by signatory countries, each propose the incorporation of ISDS measures. Given the proposed membership of these two agreements – forty countries are involved in the negotiations – and their combined contributions to global GDP and share of world trade, the proportion of world trade and investment covered by such provisions would increase several-fold.¹²⁶ Among other consequences, this would increase the potential for regulatory chill, which is a special concern for LMIC governments with limited resources. ISDS provisions could be used, for example, to challenge minimum unit pricing for alcohol, taxes on unhealthy ultra-processed foods, or nutrition labelling.¹²⁷ Thus, ISDS provisions both reflect and entrench power asymmetries with potentially destructive consequences for health. Among the questions understandably raised by critics are: why should foreign investors not be required to seek recourse through domestic court systems in countries where they invest?¹²⁸ And where is the justification for not comparably empowering citizens or civil society organizations in situations where (for example) foreign investors fail to live up to obligations as defined in international law? In contrast to many other

¹²⁴ See Hurst, D., *Australia Wins International Legal Battle with Philip Morris Over Plain Packaging*, Guardian (18 Dec. 2015), <http://www.theguardian.com/australia-news/2015/dec/18/australia-wins-international-legal-battle-with-philip-morris-over-plain-packaging>.

¹²⁵ Sud, S., Brenner, J., & Shaffer, E., *Trading Away Health: The Influence of Trade Policy on Youth Tobacco Control*, 166 J. Pediatrics 1303–1307 (2015).

¹²⁶ Meléndez-Ortiz, *supra* n. 5.

¹²⁷ Thow, A. M., Snowdon, W., Labonté, R., Gleeson, D., Stuckler, D., Hattersley, L. et al., *Will the Next Generation of Preferential Trade and Investment Agreements Undermine Prevention of Noncommunicable Diseases? A Prospective Policy Analysis of the Trans Pacific Partnership Agreement*, 119 Health Policy 88–96 (2015).

¹²⁸ Van Harten, G., *Why Arbitrators not Judges? Comments on the European Commission's Approach to Investor-State Arbitration in TTIP and CETA* (Toronto: Osgoode Hall Law School, York University 2014), http://eu-secretdeals.info/upload/2014/07/Van-Harten_Comments-id2466688.pdf.

elements of the global trend towards trade and investment liberalization, ISDS provisions have drawn criticism from a range of actors including public health physicians,¹²⁹ a number of respected economists,^{130,131,132} UN special rapporteurs and independent experts on human rights¹³³; and even *The Economist* magazine.¹³⁴

6 FUTURE DIRECTIONS

Action is required on several fronts to redress the power asymmetries in the processes of negotiating, implementing and adjudicating TIAs so as to better protect the public's health. Here we present a number of recommendations, most of which require actions by national governments.

6.1 ENSURE TRANSPARENCY AND ACCOUNTABILITY

Transparency and accountability should be improved in all stages: negotiation, implementation and adjudication of TIAs. This requires open disclosure of negotiating texts on an ongoing basis, and an immediate end to preferential corporate access to negotiating processes. It requires that departments of government with responsibilities for health protection be actively engaged in trade policy formulation, and that formal mechanisms for prospective health impact assessment of TIAs, backed by adequate resources, be put in place. It also requires opening up dispute resolution proceedings, ensuring at the very least that they generate a fully accessible public record.

6.2 PROTECT POLICY SPACE

National governments should avoid making any commitments in TIAs that will limit their ability (or the ability of lower levels of government within national

¹²⁹ Weiss, M., *Trading Health? UK Faculty of Public Health Policy Report on the Transatlantic Trade and Investment Partnership* (London: UK Faculty of Public Health 2015), <http://www.fph.org.uk/uploads/FPH%20Policy%20report%20on%20the%20Transatlantic%20Trade%20and%20Investment%20Report%20-%20FINAL.pdf>.

¹³⁰ Stiglitz, J., *On the Wrong Side of Globalization*, N.Y. Times (16 Mar. 2014), <http://opinionator.blogs.nytimes.com/2014/03/15/on-the-wrong-side-of-globalization/>.

¹³¹ Rodrik, D., *The Muddled Case for Trade Agreements*. Social Europe [On-line] (2015), <http://www.socialeurope.eu/2015/06/the-muddled-case-for-trade-agreements/>.

¹³² Johnson, L., Sachs, L., & Sachs, J., *Investor-State Dispute Settlement, Public Interest and US Domestic Law*, CCSI Policy Paper (New York: Columbia Center on Sustainable Investment 2015), <http://ccsi.columbia.edu/files/2015/05/Investor-State-Dispute-Settlement-Public-Interest-and-US-Domestic-Law-FINAL-May-19-8.pdf>.

¹³³ OHCHR (Office of the High Commissioner for Human Rights), UN experts voice concern over adverse impact of free trade and investment agreements on human rights. United Nations Human Rights [On-line] (2015), <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16031&LangID=E>.

¹³⁴ Anon, *Investor-State Dispute Settlement: The Arbitration Game*, *Economist* (11 Oct. 2014).

borders) to set what they consider appropriate standards of health protection; and should seek to renegotiate commitments now in place that have such effects. Development assistance and professional and educational exchanges should assist in building LMIC governments' capacity to assess the implications of TIAs for public health. Here priority should be given to multilateral approaches that are less likely to reflect the biases too often present in bilateral assistance, and also to South-South cooperation and exchange among developing countries.

6.3 PROTECT AND PROMOTE ACCESS TO ESSENTIAL MEDICINES AND HEALTH CARE SERVICES

Progress toward universal health coverage has become a widely accepted objective in advancing the right to health.^{135,136,137,138} Governments should avoid making any commitments that may hinder the achievement of this aim; limit access to essential medicines; or 'lock in' past decisions to involve private sector actors in health care provision and finance. They should also seek to renegotiate commitments now in place that have such effects, and support LMIC government efforts to do so as a matter of development policy.

6.4 END THE USE OF ISDS PROVISIONS AND PURSUE A NEW APPROACH TO INVESTMENT AGREEMENTS

Because ISDS provisions tend to entrench and magnify power asymmetries in ways that can be destructive of health, governments should make no new commitments to ISDS provisions built on existing models, and should seek to renegotiate those in place so as to minimize their infringement on national sovereignty and policy space. Recent trends in this direction include modifying investment agreements to incorporate exceptions related to sustainable development, or protecting regulatory policy space,¹³⁹ and

¹³⁵ Reich, MR & Takemi, K., *G8 and Strengthening of Health Systems: Follow-up to the Toyako Summit*, 373 *Lancet* 508–515 (2009).

¹³⁶ WHO, *World Health Report 2010: Health Systems Financing – The Path to Universal Coverage* (Geneva: World Health Organization 2010).

¹³⁷ UN, *Global Health and Foreign Policy*. Report No.: A/67/L.36 (New York: United Nations 2012).

¹³⁸ UN, *Transforming Our World: The 2030 Agenda for Sustainable Development – Outcome Document for the UN Summit to Adopt the Post-2015 Agenda – Finalised Text for Adoption*. *Sustainable Development Knowledge Platform* (United Nations 2015), https://sustainabledevelopment.un.org/content/documents/7888TRANSFORMING%20OUR%20WORLD_final.pdf (accessed 5 Sept. 2015).

¹³⁹ UNCTAD (United Nations Conference on Trade and Development), *Recent Trends in IIAS and ISDS*, Issues Note No. 1 (New York: UNCTAD 2015b), http://unctad.org/en/PublicationsLibrary/webdiaepcb2015d1_en.pdf.

termination of existing bilateral investment treaties by countries including South Africa and Indonesia.¹⁴⁰

6.5 PERMIT STATES' TREATY OBLIGATIONS AS ARGUMENTS IN DISPUTE RESOLUTION

In dispute resolution proceedings, governments should seek to defend measures that would otherwise be considered impermissible restrictions on trade and investment on the grounds that they reflect obligations under relevant treaties that the government in question has ratified (such as the obligation to respect, protect and fulfil the right to health or to implement the Framework Convention on Tobacco). National governments should seek to incorporate into TIAs provisions that protect this defence; should make no commitments that would interfere with the ability to mount such defences, and should seek to renegotiate existing commitments that have this effect. Among other consequences, implementing this recommendation will immediately enhance the position of health ministries and other agencies with a health-related remit in the process of determining national positions on trade policy, and provide a new and much-needed window of opportunity for civil society.

We end with a more positive and forward-looking recommendation, since current negotiations and preoccupations tend to crowd out space for discussion of viable alternatives.

6.6 THINK NEW

Governments, civil society and multilateral organizations should rethink the purpose of trade and trade agreements, so that they foster wellbeing rather than serving to promote and enforce investment interests. This can lead to new options for international trade cooperation, including cooperation on rules designed to serve a wider set of public policy/health goals, such as agreements on technology transfer, research and development investment, and new approaches to financing medical innovation.^{141,142} The adoption of the Sustainable Development Goals¹⁴³ may offer the opportunity for such initiatives.

¹⁴⁰ United Nations Conference on Trade and Development, *World Investment Report 2015: Reforming International Investment Governance* (New York and Geneva: United Nations 2015c), http://unctad.org/en/PublicationsLibrary/wir2015_en.pdf.

¹⁴¹ Hollis, A., *The Health Impact Fund: A Useful Supplement to the Patent System?*, 1 *Pub. Health Ethics* 124–133 (2008).

¹⁴² Moon S., Bermudez J., & 't Hoen E., *Innovation and Access to Medicines for Neglected Populations: Could a Treaty Address a Broken Pharmaceutical R&D System?* 9 *PLoS Medicine* e1001218 (2012).

¹⁴³ UN, *supra* n. 138.